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Section

501.001: Definition of Terms

The terms listed in 130 CMR 501.001 have the following meanings for the purposes of MassHealth, as described in 130 CMR 501.000 through 508.000.

Access to Health Insurance – the ability to obtain employer-sponsored health insurance for an uninsured family group member where an employer would contribute at least 50 percent of the premium cost, and the health insurance offered would meet the basic-benefit level.

American Indian or Alaska Native – a person who is a member of a federally recognized tribe, band, or group; or an Eskimo, Aleut, or other Alaska Native enrolled by the Secretary of the Interior, pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 et seq.

Appeal – a written request, by an aggrieved applicant or member, for a fair hearing.

Appeal Representative – a person who:

(1) is sufficiently aware of an appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has provided the Board of Hearings with written authorization from the appellant to act on the appellant's behalf during the appeal process;

(2) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or

(3) is an eligibility representative meeting the requirements of (1) or (2) above.

Applicant – a person who completes and submits a Medical Benefit Request.

Basic-Benefit Level (BBL) – benefits provided under a health-insurance plan that are comprehensive and comparable to benefits provided by insurers in the small-group health-insurance market. Health-insurance plans that meet the requirements of 211 CMR 64.00 also meet the BBL.

Billing and Enrollment Intermediary (BEI) – a health-insurance intermediary, registered with the Massachusetts Division of Insurance pursuant to 211 CMR 66.13(3), that performs billing and enrollment services, and has entered into a contract with the Division to perform the services stated in 130 CMR 650.009.

Blindness – a visual impairment, as defined in Title XVI of the Social Security Act. Generally "blindness" means visual acuity with correction of 20/200 or less in the better eye, or a peripheral field of vision contracted to a 10-degree radius or less, regardless of the visual acuity.

Business Day – any day during which the Division's offices are open to serve the public.

Caretaker Relative – an adult who is the primary care giver for a child, is related to the child by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.

Case File – the permanent written collection of documents and information required to determine eligibility and to provide benefits to applicants and members.

Child – a person under age 19.

Complete Medical Benefit Request – a Medical Benefit Request that is received by the Division and includes all required information and verifications including, where applicable, a completed disability supplement.

Couple – two persons who are married to each other, live together, and have no children under the age of 19 living with them.

Couple Policy – a health-insurance policy that covers a married couple. If an employer does not offer a couple policy, a married couple may be covered under a family policy.

Coverage Date – the date medical coverage begins.

Coverage Types – a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria. These coverage types include the following: MassHealth Standard (Standard), MassHealth CommonHealth (CommonHealth), MassHealth Family Assistance (Family Assistance), MassHealth Basic (Basic), MassHealth Essential (Essential), MassHealth Prenatal (Prenatal), and MassHealth Limited (Limited). The scope of services or covered benefits for each coverage type is found at 130 CMR 450.105.

Day – a calendar day unless a business day is specified.

Disabled – having a permanent and total disability.

Disabled Working Adult or 18-Year-Old – a person who is engaged in substantial gainful activity but otherwise meets the definition of disabled, as defined in Title XVI of the Social Security Act.

Disability Determination Unit – a unit that consists of physicians and disability evaluators who determine permanent and total disability using criteria established by the Social Security Administration under Title XVI, and criteria established under state law. This unit may be a part of a state agency or under contract with a state agency.

Eligibility Process – activities conducted for the purposes of determining, redetermining, and maintaining the eligibility of a MassHealth applicant or member.

Eligibility Representative – a person who:

(1) has, under applicable law, authority to act on behalf of an applicant or member in making decisions related to health care or payment for health care. An eligibility representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or

(2) is sufficiently aware of the applicant's or member's circumstances to assume responsibility for the accuracy of the statements made during the eligibility process, and who fulfills at least one of the following two conditions:

(a) has provided the Division with written authorization from the applicant or member to act on the applicant's or member's behalf during the eligibility process; or

(b) is acting responsibly on behalf of an applicant or member for whom written authorization cannot be obtained.

Fair Hearing – an administrative, adjudicatory proceeding conducted according to 130 CMR 610.000 to determine the legal rights, duties, benefits, or privileges of applicants and members.

Family – persons who live together, and consists of: (1) a child or children under age 19, any of their children, and their parents; (2) siblings under age 19 and any of their children who live together even if no adult parent or caretaker relative is living in the home; or (3) a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family. A parent may choose whether or not to be included as part of the family of a child under age 19 only if that child is: a) pregnant; or b) a parent. A child who is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children who live with them.

Family Group – a family, couple, or individual.

Family Policy – a health-insurance policy that covers one or more adults, with one or more children. If an employer does not offer a couple policy, or a one-adult with one-child policy, a couple without children, or a family with one adult and one child may be covered by a family policy.

Federal-Poverty Level (FPL) – income standards issued annually in the *Federal Register* to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Fee-for-Service – a method of paying for medical services provided by any MassHealth participating provider with no limit on provider choice.

Gross Income – the total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Health Insurance – coverage of health-care services by a health-insurance company, a hospital-service corporation, a medical-service corporation, a managed-care organization, or Medicare. Coverage of health-care services by the Division of Medical Assistance or the Department of Public Health (e.g., MassHealth or Children's Medical Security Plan (CMSP)) is not considered health insurance.

Individual – any person not included in the definition of a family or couple.

Individual Policy – a health-insurance policy that covers the policyholder only.

Insurance Partnership Agent (IPA) – the organization under contract with the Division to help administer the Insurance Partnership, as described in 130 CMR 650.009. The IPA administers Insurance Partnership payments for those qualified employers who do not obtain employee health-insurance coverage through a BEI or an entity linked to a BEI.

Interpreter – a person who translates for an applicant or member who has limited English proficiency or a hearing impairment.

Large Employer – an employer that:

(1) has more than 50 employees who work 30 or more hours a week;

(2) offers health insurance that meets the basic-benefit level; and

(3) contributes at least 50 percent of the cost of the employees' health-insurance premiums.

Limited English Proficiency – an inadequate ability to communicate in the English language.

Managed Care – a system of primary care and other medical services that are provided and coordinated by a MassHealth managed-care provider in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000 et seq.

Managed-Care Organization (MCO) – any entity with which the Division contracts to provide primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO), or that otherwise meets the State Plan definition of an HMO.

MassHealth Managed-Care Provider – a primary-care clinician or managed-care organization that has contracted with the Division to provide and coordinate primary care and certain other medical services to certain MassHealth members.

Medical Benefit Request (MBR) – a form prescribed by the Division to be completed by the applicant or an eligibility representative, and submitted to the Division as a request for MassHealth benefits.

Medical Benefits – payment for health insurance or medical services provided to a MassHealth member.

Member – a person determined by the Division to be eligible for MassHealth.

One-Adult-with-One-Child Policy – a health-insurance policy that covers a family consisting of one adult and one child.

Permanent and Total Disability – a disability as defined under Title XVI of the Social Security Act or under applicable state laws.

(1) For Adults and 18-Year-Olds.

(a) The condition of an individual, aged 18 or older, who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that:

(i) can be expected to result in death; or

(ii) has lasted or can be expected to last for a continuous period of not less than 12 months.

(b) For purposes of this definition, an individual aged 18 or older is determined to be disabled only if his or her physical or mental impairments are of such severity that the individual is not only unable to do his or her previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. "Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(2) For Children Under Age 18. The condition of an individual under the age of 18 who has any medically determinable physical or mental impairment, or combination of impairments, of comparable severity to an impairment or combination of impairments that disables an adult, or are of such severity that the child is unable to engage in age-appropriate activities, as defined in Title XVI as in effect on July 1, 1996.

Person Who Is HIV Positive – a person who has submitted verification that he or she has tested positive for the human immunodeficiency virus (HIV).

Premium – a charge for payment to the Division that may be assessed to members of MassHealth Standard, MassHealth CommonHealth, or MassHealth Family Assistance.

Premium Assistance Payment – an amount contributed by the Division toward the cost of employer-sponsored health-insurance coverage for certain MassHealth members.

Presumptive Eligibility – a time-limited period of conditional eligibility for children based on the applicant's declaration of family group gross income.

Primary-Care Clinician (PCC) Plan – a managed-care option administered by the Division through which enrolled members receive primary care and other medical services. See 130 CMR 450.118.

Qualified Employer – a small employer who:

(1) purchases health insurance that meets the Basic-Benefit Level;

(2) contributes at least 50 percent of the cost of employees' health-insurance premiums; and

(3) has completed an Employer Application form and been approved by the Division or its contractor(s) as a qualified employer pursuant to 130 CMR 650.010(A).

Quality Control – a system of continuing review to measure the accuracy of eligibility decisions.

Senior Care Organization – an organization that participates in MassHealth under a contract with the Division and the Centers for Medicare and Medicaid Services to provide a comprehensive network of medical, health-care, and social-service providers that integrates all components of care, either directly or through subcontracts. Senior care organizations are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Small Business – see definition for small employer.

Small Employer – an employer that has no more than 50 employees who work 30 hours or more a week, or a self-employed individual.

Substantial Gainful Activity – generally, employment that provides a set amount of gross earnings as determined by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

Third Party – any individual, entity, or program that is or may be responsible to pay all or part of the expenditures for medical benefits.

501.002: Introduction to MassHealth

(A) The MassHealth agency is responsible for the administration and delivery of health-care services to eligible low- and moderate-income individuals, couples, and families under MassHealth.

(B) 130 CMR 501.000 through 508.000 (referred to as Volume I) provide the MassHealth requirements for children, families, disabled persons, persons who are HIV positive, women with breast or cervical cancer, and certain individuals or couples who are under age 65 and not institutionalized. These requirements are prescribed under an 1115 Medicaid Research and Demonstration Waiver approved by the U.S. Department of Health and Human Services on April 24, 1995, and authorized by Chapter 203 of the Massachusetts Acts and Resolves of 1996: An Act Providing Improved Access to Health Care; and under Title XXI of the Social Security Act and authorized by Chapter 170 of the Massachusetts Acts and Resolves of 1997: An Act Expanding Access and Quality Health Care for Working Families, Children, and Senior Citizens in the Commonwealth.

(C) 130 CMR 515.000 through 522.000 (referred to as Volume II) provide the MassHealth requirements for persons who are institutionalized, aged 65 or older, or who would be institutionalized without community-based services as defined by Title XIX of the Social Security Act.

(D) The MassHealth agency will determine eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003 and as described in federal regulations at 20 CFR Part 418.

501.003: MassHealth Coverage Types

(A) The MassHealth agency provides access to health care by determining eligibility for the coverage type that provides the most comprehensive benefits for an individual or family who may be eligible.

(B) MassHealth offers several coverage types: Standard, Prenatal, CommonHealth, Family Assistance, Basic, Essential, and Limited. The coverage type for which a person is eligible is determined based on the individual's income and circumstances, as described in 130 CMR 503.000 through 505.000.

(C) The MassHealth agency may limit the number of people who can be enrolled in MassHealth CommonHealth, MassHealth Family Assistance, and MassHealth Essential. When the MassHealth agency imposes such a limit, no new adult applicants (aged 19 or older) subject to these limitations will be added to these coverage types, and current adult members in these coverage types who have lost eligibility for more than 30 days for any reason will not be allowed to reenroll until the MassHealth agency is able to reopen enrollment for adults in these coverage types. Excluded from these limitations are parents receiving benefits under 130 CMR 505.005(C).

(D) Applicants who cannot be enrolled under MassHealth CommonHealth, MassHealth Family Assistance, or MassHealth Essential, pursuant to 130 CMR 501.003(C), will be placed on a waiting list when their eligibility has been determined. When the MassHealth agency is able to open enrollment for adult applicants, the applications will be processed in the order they were placed on the waiting list.

(E) (1) Medical coverage for MassHealth CommonHealth for persons who are enrolled from a waiting list will begin on the date that the application or new determination is processed from the waiting list.

(2) (a) Family Assistance Premium Assistance payments for persons enrolled from the waiting list will begin in the month that the application or new determination is processed from the waiting list, or in the month that the health insurance deduction begins, whichever is later.

(b) Medical coverage for Family Assistance Purchase of Medical Benefits for persons who are enrolled from a waiting list will begin on the date that the application or new determination is processed from the waiting list.

(3) (a) Essential Premium Assistance payments for persons enrolled from the waiting list will begin in the calendar month following verification of the member's health insurance information. Coverage before enrollment for MassHealth Essential members who are aliens with special status is described in 130 CMR 505.007(E).

(b) Medical coverage for Essential Purchase of Medical Benefits for persons enrolled from a waiting list will begin on the date specified in MassHealth's notice of enrollment in the MassHealth Primary Care Clinician (PCC) Plan. There is no coverage for Essential members before the member's effective enrollment date, except as described in 130 CMR 505.007(E) for aliens with special status eligible for MassHealth Essential with MassHealth Limited.

501.004: Administration of MassHealth

(A) MassHealth. MassHealth formulates requirements and determines eligibility for all MassHealth coverage types.

(B) Other Agencies.

(1) Department of Transitional Assistance (DTA).

(a) The Department of Transitional Assistance administers the Transitional Aid to Families with Dependent Children (TAFDC) Program. Persons who meet the requirements of section 1931 of Title XIX (42 U.S.C. § 1396u-1) are automatically eligible for MassHealth Standard coverage.

(b) DTA also administers the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program. Uninsured individuals and members of a couple receiving EAEDC cash assistance are automatically eligible for the purchase of medical benefits under MassHealth Basic upon managed-care enrollment, in accordance with the requirements of 130 CMR 508.000. Insured individuals and members of a couple receiving EAEDC cash assistance are automatically eligible for premium assistance under MassHealth Basic. Eligibility requirements for aliens with special status, as described in 130 CMR 504.002(D), who are aged 19 through 64, and receiving EAEDC, are detailed in 130 CMR 505.007(E). Families receiving EAEDC are automatically eligible for MassHealth Standard coverage and are provided choices of enrollment in a managed care plan, unless exempt in accordance with 130 CMR 508.004, except as described in 130 CMR 505.007(E).

(2) Social Security Administration (SSA). District Social Security Offices administer the SSI program and determine the eligibility of disabled individuals. Individuals receiving SSI are automatically eligible for MassHealth Standard coverage. Individuals without health insurance are provided choices of enrollment in a managed care plan.

(3) Department of Public Health (DPH). The Department of Public Health administers the Women's Health Network, which provides breast and cervical cancer screening and diagnostic services to certain low-income women. Uninsured women who are screened or receive diagnostic services through the Women's Health Network are eligible for MassHealth Standard for the duration of their cancer treatment if they:

(a) are found to be in need of treatment for breast or cervical cancer; and

(b) meet the MassHealth program requirements described in 130 CMR 505.002(H), as determined by MassHealth.

(4) Department of Employment and Training (DET). The Department of Employment and Training administers the Medical Security Plan that provides health insurance to persons who are receiving, or who are eligible to receive, state or federal unemployment benefits. Coverage is offered either through direct purchase of coverage or partial reimbursement for insurance premium payments.

501.005: Individuals and Families Eligible for or Receiving Medical Assistance on June 30, 1997

(A) Members Who Were Not Subject to a Deductible. Individuals and families (including caretaker relatives) who were receiving Medical Assistance on June 30, 1997, and whose family group gross income on June 30, 1997 exceeded MassHealth eligibility standards will be provided MassHealth Standard coverage for one year after the date of MassHealth implementation, except in the following circumstances: 1) the individual or family no longer lives in Massachusetts; 2) the individual enters an institution; 3) the individual turns 65; 4) the individual or all members of the family are deceased; or 5) the individual or family is no longer categorically eligible. Eligibility for continuing coverage will be reviewed toward the end of this one-year period.

(B) Families Who Have Met a Deductible. Families (including caretaker relatives) with children under 18 who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who were denied with a deductible before July 1, 1997, and subsequently meet a deductible on or after July 1, 1997, and whose family group gross income exceeds MassHealth standards will be eligible for MassHealth Standard for one year from the end of the deductible period, except in the following circumstances:

(1) the individual or family no longer lives in Massachusetts;

(2) the individual enters an institution;

(3) the individual turns 65;

(4) the individual or all members of the family are deceased; or

(5) the individual or family is no longer categorically eligible.

A determination of eligibility for MassHealth will be made toward the end of the one-year period.

(C) Disabled Individuals Who Have Met a Deductible. Disabled individuals who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who meet a deductible on or after July 1, 1997, will have their continuing eligibility for MassHealth determined in accordance with 130 CMR 506.009.

501.006: Children Receiving Benefits under the Children's Medical Security Plan on August 3, 1998

(A) Eligibility.

(1) Children who were receiving benefits under the Children's Medical Security Plan on August 3, 1998, as well as any siblings in their family group, will be treated as a protected status group under MassHealth if they:

(a) have submitted a complete Medical Benefit Request as defined in 130 CMR 502.001 by March 31, 1999;

(b) meet the eligibility requirements of MassHealth; and

(c) have a family group gross income less than or equal to 200 percent of the FPL.

(2) Families of children described in 130 CMR 501.006(A)(1) who are determined eligible for MassHealth Family Assistance will have the option of choosing purchase of medical benefits or premium assistance under MassHealth Family Assistance if the Division determines the child has access to health insurance from an employer other than the Commonwealth of Massachusetts.

(B) Loss of Protected Status. The protected status of a child described in 130 CMR 501.006(A) will end in the following circumstances:

(1) the family group's gross income exceeds 200 percent of the FPL;

(2) the family fails to cooperate with the Division's eligibility review; or

(3) the child no longer meets MassHealth requirements.

501.007: Receiving Public Assistance from Another State

Persons who are receiving public assistance from another state are not eligible for MassHealth.

501.008: Massachusetts Commission for the Blind (MCB)

Blind individuals aged 19 through 64 may submit requests for MassHealth to the Massachusetts Commission for the Blind.

501.009: Rights of Applicants and Members

The policies of the MassHealth Program are administered in accordance with federal and state law. Applicants and members must be informed of their rights and responsibilities with respect to the MassHealth Program.

(A) Right to Nondiscrimination and Equal Treatment. The Massachusetts Division of Medical Assistance does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, disability, or age in admission or access to, or treatment or employment in, its programs or activities. Grievance procedures for resolution of discrimination complaints are administered and applied by the Division's Affirmative Action Office.

(B) Right to Confidentiality. The confidentiality of information obtained by the Division during the MassHealth eligibility process is protected in accordance with federal and state regulations. The use and disclosure of information concerning applicants, members, and legally liable third parties is restricted to purposes directly connected with the administration of MassHealth as governed by state and federal law.

(C) Right to Timely Provision of Benefits. Eligible applicants and members have the right to the timely provision of benefits as defined in 130 CMR 502.000.

(D) Right to Information. Persons who inquire about MassHealth, either orally or through a written request, have the right to receive information about medical benefits, coverage type requirements, and their rights and responsibilities as applicants and members of MassHealth.

(E) Right to Apply. Any person, individually or through an eligibility representative, has the right, and must be afforded the opportunity without delay, to apply for MassHealth.

(F) Right to be Assisted by Others.

(1) The applicant or member has the right to be accompanied and represented by an eligibility representative during the eligibility process, and by an appeal representative during the appeal process. The Division must provide copies of all eligibility notices to an applicant's or member's eligibility representative, and must provide copies of all documents related to the fair hearing process to an applicant's or member's appeal representative.

(2) An application for MassHealth may be filed by an eligibility representative on behalf of a deceased person.

(3) An appeal on behalf of a deceased person may be filed by an appeal representative, as defined in 130 CMR 501.001.

(G) Right to Inspect the MassHealth Case File. The applicant or member has the right to inspect information in his or her MassHealth case file and contest the accuracy of the information.

(H) Right to Appeal. The applicant or member has the right to appeal and request a fair hearing as the result of any adverse action or inaction taken by the Division. The request will not be granted if the sole issue is a federal or state law requiring an automatic change adversely affecting members.

(I) Right to Interpreter Services. The Division will inform applicants and members of the availability of interpreter services. Unless the applicant or member chooses to provide his or her own interpreter services, the Division will provide either telephonic or other interpreter services whenever:

(1) the applicant or member who is seeking assistance from the Division has limited English proficiency or sensory impairment and requests interpreter services; or

(2) the Division determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. The Division will provide a Certificate of Creditable Coverage to members whose coverage under MassHealth Standard or CommonHealth, or a MassHealth health plan under Family Assistance, Basic, or Essential has ended. The Division will issue a Certificate to members within one week of their MassHealth termination, or within one week of the request for a Certificate, as long as the request is made within 24 months of their MassHealth termination. The Certificate may allow members to waive or reduce the length of preexisting-condition waiting periods when they enroll in a new health plan offered by other insurance. If a member's MassHealth termination also terminates the coverage of his or her dependents, the dependents will be included on the Certificate.

501.010: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with MassHealth in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining available health insurance.

(B) Responsibility to Report Changes. The applicant or member must report to MassHealth, within 10 days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

(C) Cooperation with Quality Control. The Quality Control Division will periodically conduct an independent review of eligibility factors in a sampling of case files. When a case file is selected for review, the member must cooperate with the representative of Quality Control. Cooperation includes, but is not limited to, a personal interview and the furnishing of requested information. If the member does not cooperate, MassHealth benefits may be terminated for the family group.

501.011: Referrals to Investigative Units

Intentional false statements or fraudulent acts made in connection with obtaining medical benefits or payments under MassHealth are punishable under M.G.L. c. 118E, § 39 by fines, imprisonment, or both. In all cases of suspected fraud, MassHealth staff will make a referral to the Bureau of Special Investigations, or other appropriate agencies.

501.012: Recovery of Overpayment of Medical Benefits

MassHealth has the right to recover payment for medical benefits to which the member was not entitled, regardless of who was responsible and whether or not there was fraudulent intent. No provision under 130 CMR 501.012 will limit MassHealth's right to recover overpayments.

501.013: Estate Recovery

(A) Introduction.

(1) MassHealth will recover the amount of payment for medical benefits correctly paid from the estate of a deceased member. Recovery is limited to payment for all services provided while the member was aged 55 or older.

(2) The estate includes all real and personal property and other assets in the member's probate estate.

(B) Deferral of Estate Recovery. Recovery will not be required until after the death of a surviving spouse, if any, or while there is a surviving child who is under 21 years of age, or a child of any age who is blind or permanently and totally disabled.

(C) Waiver of Estate Recovery Due to Hardship. For claims presented on or after November 15, 2003, recovery will be waived if:

(1) a sale of real property would be required to satisfy a claim against the member's estate; and

(2) a person who was using the property as a principal place of residence on the date of the member's death meets all of the following conditions:

(a) the person lived in the property on a continual basis for at least one year immediately before the now-deceased member became eligible for MassHealth or other assistance from the Division and continues to live in the property at the time the Division first presented its claim for recovery against the deceased member's estate;

(b) the person has inherited or received an interest in the property from the deceased member's estate as defined in 130 CMR 501.013(A)(2) and 515.011(A)(2);

(c) the person is not being forced to sell the property by other devisees or heirs at law; and

(d) at the time the Division first presented its claim for recovery against the deceased member's estate, the gross annual income of the person's family group, as defined in 130 CMR 501.001, was less than or equal to 133 percent of the applicable federal-poverty-level income standard for the appropriate family size.

(3) The waiver will be conditional for a period of two years from the date the Division mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for the Division to waive recovery still exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period, the circumstances and conditions for the waiver no longer exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), or the property is sold or transferred, or the person does not use the property as their primary residence, the Division will be notified and its claim will be payable in full.

(D) Outstanding Claims.

(1) For claims presented between April 1, 1995, and November 15, 2003, that are still outstanding, recovery will be waived if all requirements under the Division's then-existing regulations were met.

(2) For claims presented before April 1, 1995, a waiver for hardship did not exist.

(E) Fair-Market Value and Equity Value. If there will be insufficient proceeds from the sale or transfer of the property to satisfy the Division's claim in full, the fair-market value and equity value of all real property that is part of the deceased member's estate must be verified prior to the sale or transfer of said property.

(1) The executor or administrator of the probate estate, or in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must verify the fair-market value by sending to the Division a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

(a) a special-purpose tax assessment;

(b) based on a fixed-rate-per-acre method; or

(c) based on an assessment ratio or providing only a range.

(2) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must also provide a comparable market analysis or a written appraisal of the property value from a knowledgeable source. A knowledgeable source includes one of the following: a licensed real-estate agent or broker, a real-estate appraiser, or an official of a bank, savings and loan association, or similar lending organization. The knowledgeable source must not have any real or apparent conflict-of-interest relationship with the estate.

(3) The Division may also obtain an assessment from a knowledgeable source.

501.014: Voter Registration

(A) Voter registration forms will be made available through the Division of Medical Assistance to applicants and members who are:

(1) U.S. citizens; and

(2) aged 18 or older, or who will be aged 18 on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.

(B) Applicants and members will be:

(1) informed of the availability of voter registration forms at application, at the time of an eligibility review, and when there is an address change;

(2) offered assistance in completing the voter registration form unless such assistance is refused; and

(3) able to submit voter registration forms, in person or by mail, to the Division of Medical Assistance for transmittal to the proper election offices.

(C) Division staff must not:

(1) seek to influence an applicant's or member's political preference or party registration;

(2) display any political preference or party allegiance to the applicant or member;

(3) make any statement to an applicant or member or take any action intended to influence the applicant's or member's decision regarding voter registration; or

(4) make any statement to an applicant or member or take any action intended to lead the applicant or member to believe that the decision to register or not has any bearing on the availability of services or benefits.

(D) Completed voter registration forms that are submitted to the Division of Medical Assistance will be transmitted to the proper local election office for processing within five days of receipt.